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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.	F 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 159	Continued From page 1 The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This Requirement is not met as evidenced by: The facility had a census of 97 residents and managed funds for 23 residents. Based on interview and record review, the facility failed to obtain written authorization prior to managing the funds for 1 resident (#80) of the 6 resident fund accounts reviewed. Findings included: - On 10/29/14 at 4:30 PM, review of the resident trust fund account revealed resident #80 lacked a signed consent for the facility to manage the resident monies. Review of the resident's current ledger revealed staff recorded on 1/2/15, a $70.00 balance brought forward from the previous year's (2014) ledger, which indicated the facility had managed the resident's monies for some time. On 10/29/15 on 3:30 PM, administrative staff D stated the facility became the payee for resident #80 on February, 2012, and started managing the resident's funds at that time. At that time, administrative staff D verified the facility failed to obtain a written authorization to handle the resident's monies. The facility's resident personal funds policy and	F 159		

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F 159	Continued From page 2 procedure, updated 4/25/12, recorded upon written authorization of an elder, the facility shall manage the funds of the elder that are deposited with the organization. Before any money can be deposited into an account on behalf of the elder, a resident personal funds account authorization form must be completed and signed. The facility failed to obtain written authorization prior to managing the funds for this resident, which the facility had managed since 2/12.	F 159		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: The facility reported a census of 97 residents, who resided on 8 nursing units. Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services for 43 residents on 2 of the 8 nursing unit's beauty shop and residents common living area. Findings included: - Observation, on 10-27-15 at 8:30 am, with maintenance staff B, revealed the beauty shop contained the following areas of concern: 1. The shampoo bowl hose contained corroded discolored metal plumbing components, and spigot with grime and the build-up of a black substance. 2. The step on trash can, contained grime across	F 253		

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F 253	Continued From page 3 the exterior. 3. Four hair dryers contained a large accumulation of a white substance (lint/dust) on the filters and dust on the upholstery. 4. Three, gallon size containers, of hair care products contained hair and grime across the exterior surfaces of the containers. Also 8 smaller bottles of hair care products of varying sizes contained hair and sticky discolored substances across the exteriors of the containers. 5. The shelves of a bookcase, which contained various hair care products, contained a layer of dust and grime. 6. An upright plastic drawer unit, contained perm rods with hair, and used perm papers with grime. 7. The air vent on the floor contained a build-up of dust and hair. 8. The floor contained multiple scrapes with black scuff marks and the floor perimeter contained an accumulation of grime and hair. 9. The chair by the shampoo bowl contained an accumulation of white grime, and the mat beneath the chair contained grime and hair build-up. Interview, on 10-27-15 at 8:30 am, with maintenance staff B, confirmed the above observations. Staff B stated he/she needed to put the beauty shop floors on a routine cleaning schedule. Interview, on 10-30-15 at 10:30 am, with house keeping staff N, revealed the housekeepers	F 253		

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should be responsible to clean the beauty shop floors.

The facility agreement for cosmetology services, dated 9-23-11, ensured the facility would provide a suitable space for the provision of services which conformed to meet regulatory requirements and make changes to maintain the physical environment.

The undated facility policy for (the building which held these 2 nursing units) cleaning schedule, failed to indicate any cleaning of the beauty shop area.

Furthermore, during the environmental tour at 9:15 am, with maintenance staff B, (1 of the 2 nursing units in this building), revealed the carpet on 1 nursing unit's common living areas contained multiple stains ranging from approximately 4 to 12 inches.

Maintenance staff B stated, at this time, that the facility was aware of the nursing unit's carpet's condition.

The other nursing unit's dining area, contained flooring with multiple black scruff marks and black grime build-up along the floor by the kitchen.

During this observation, Maintenance staff B stated the facility did have a floor care provider that did not complete the maintenance services in a satisfactory manner.

The elevator for this building (which contained 2 nursing units with 43 residents), contained 5 panels with vertical scrapes across the width of the lower panels, leaving unpainted surface.

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F 253	Continued From page 5 The (building with 2 nursing units) undated, cleaning schedule, lacked guidance for floor/carpet cleaning, but advised staff to notify maintenance of deficiencies in the building. The facility failed to provide housekeeping and maintenance services for these 2 nursing units (in this building) with 43 residents, to maintain the beauty shop, elevator, and the 2 nursing units flooring in a sanitary and comfortable manor for these residents of the facility.	F 253		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This Requirement is not met as evidenced by: The facility reported a census of 97 residents, with 43 who resided on 2 nursing units. Based on observation and interview, the facility failed to provide a comfortable temperature for the 43 residents of these 2 nursing units. Findings included: - On 10/27/15 various residents who resided on the 2 nursing units in 1 building, revealed complaints of being too cold in the facility as follows: Interview, on 10-27-15 at 12:34 pm, with resident #59 revealed he/she felt it was always cold in his/her room and in the lobby area. The resident reported he/she thought there was only a central control for the facility heating/cooling.	F 257		

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Interview, on 10-27-15 at 2:06 pm, with resident #103, revealed he/she felt is was cold in their room, and wore heavy clothes, socks and covered him/herself with blankets. The resident felt the facility still had the air conditioner on and he/she had no way to control the cool air.

Interview, on 10-27-15 at 2:40 pm, with resident #57 revealed he/she felt cool air in spite of the room control being turned off. The temperature on the resident's room thermostat read as 71.8 degrees Fahrenheit.

Interview, on 10-27-15 at 2:59 pm, with resident #60 revealed he/she felt is was cold in his/her room. The resident stated it was too cold to take a shower. The temperature in the room at this time recorded as 68.9 degrees Fahrenheit.

Interview, on 10-27-15 at 3:54 pm, with resident #2, revealed he/she felt cold in his/her room and did not want to take a shower because he/she would be cold afterward in his/her room and while in the shower. The temperature in the room at this time recorded as 67.2 degrees Fahrenheit.

Interview, on 10-29-15 at 7:30 am, with direct care staff L, revealed there was no way to regulate the temperature on the nursing units.

Environment tour, on 10-30-15 at 9:15 am, with maintenance staff B, revealed the facility used a boiler/chiller system and the chiller remained on at this time. The thermometer in the common living areas on the 2 nursing units (in this building) was set at 70.2 degrees Fahrenheit. Staff B explained the residents heating/cooling units in their individual rooms could be in the "off" position to stop the cool air from circulating in their rooms, but the system could not circulate

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F 257	Continued From page 7 any warm air at this time. The facility undated policy for the Boiler/Chiller, advised staff of the Vice President of Support Services to manipulate the boiler and chiller systems in (the building with 2 nursing units) to maintain the temperature to meet the environmental standards and comfort of the residents receiving care in (these 2 nursing units). The facility failed to ensure the provision of comfortable temperatures for the 43 residents who reside in these 2 nursing units in this building.	F 257		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by:	F 280		

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The facility had a census of 97 residents. The sample included 23 residents. Based on observation, record review, and interview, the facility failed to review and revise 5 of the 23 sampled residents care plans including; (#27) for behaviors, (#65) with urinary indwelling catheter, (#2 and #60) for falls, and (#33) with side rails.

Findings included:

- Review of resident #27's signed physician orders, dated 10/8/15, revealed the resident readmitted on 8/25/15, with the following diagnosis included; anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), agitation, delirium (sudden severe confusion, disorientation and restlessness), and dementia (progressive mental disorder characterized by failing memory, confusion).

The admission MDS (minimum data set), dated 6/10/15, revealed the resident had a BIMS (brief interview for mental status) score of 8, indicating moderately impaired cognition. The resident had delirium, inattention and disorganized thinking, with the behavior present which fluctuated. The resident with a mood score of 3, which indicated minimal depression. The resident had verbal behavioral symptoms directed toward others, rejection of care, and the behavior occurred on 1-3 days. The resident required extensive staff assistance for ADL's (activities of daily living). The resident received an antianxiety medication.

The CAA (care area assessment), dated 6/10/15, for cognition, documented the resident was a new admission with a diagnosis of altered mental status and demonstrated memory loss with periods of confusion and altered thinking. For

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behaviors, the care tracker charting documented the resident can be verbal and "reject" cares.

The quarterly MDS, dated 9/8/15, revealed the resident had a BIMS score of 13, indicating intact cognition; physical behavioral symptoms directed toward others, and the behavior occurred on 1-3 days. The resident required limited staff assistance for transfers, toilet use, and personal hygiene. The resident received an antipsychotic and antianxiety medication.

The care plan, reviewed on 9/15/15, documented the resident had impaired cognition; a diagnosis of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure) dementia, and the resident's short/long term memory was inadequate. The care plan instructed staff to provide reorientation and monitor for effectiveness, and to provide time for the resident to process things cognitively; using simple "yes/no" questions.
The resident was at risk for depression/impaired mood due to recent changes in living environment and impaired cognition. The care plan instructed staff to contact the psychiatric doctor as ordered for mood and behavior change, and to document changes in the care tracker and nurses notes for trending and monitoring.
The care plan lacked specific behavior interventions for this resident who received antipsychotic and antianxiety medications.

The nursing progress notes, dated 10/15/15, documented the resident was attention seeking, making multiple requests, which would improve when taking haldol (antipsychotic). However, this medication had been discontinued due to a potential medication interaction. The resident was sent to the hospital and returned with the

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following physician orders, to increase Seroquel (antipsychotic medication), to 25 mg (milligrams), 1 by mouth twice daily, add Celexa (antidepressant medication), 10 mg, 1 by mouth every AM to target anxiety, and increase as needed Ativan (antianxiety medication) to 0.5 mg, 1 by mouth every 6 hours PRN (as needed) for anxiety.

The AIMS (abnormal involuntary movement score) dated 10/2/15, documented the resident was without any abnormal movements.

Review of the residents behavior monitoring for August, 2015, revealed the resident was without any behaviors. Review of the September, 2015, behavior monitoring revealed on 9/3/15 at 8:59 PM, the resident was anxious and the staff intervention was conversation, however it did not help. Review of the October, 2015, behavior monitoring revealed the resident was without any behaviors.

On 10/28/15 at 4:00 PM, observation revealed the resident resting quietly in bed with eyes closed.

On 10/29/15 at 11:25 PM, direct care staff U assisted the resident into his/her wheelchair. The resident was in a good mood. The resident talked about his/her new shoes he/she had on. The resident was without any negative behaviors.

On 10/29/15 at 4:30 PM, observation revealed the resident sitting at the dining room table drinking a glass of juice. The resident was without any negative behaviors.

On 10/29/15 at 11:29 PM, direct care staff V stated the resident does not use his/her call light, but would yell help, help repeatedly. Staff V also

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stated he/she had never known the resident to be physical with staff or another resident. Behaviors were documented by the CNAs (certified nursing aides) in the Kiosk (CNA electronic documentation) and the CNAs would let the nurse know. When the resident became anxious, if staff bring the resident out with the other residents and talk with him/her, the resident would be fine.

On 10/29/15 at 3:50 PM, direct care staff T stated the resident would call out at times, and usually would yell for help. The resident just wanted someone with him/her and give the resident a little 1 on 1 and the resident would be fine. Direct care staff T stated he/she would document the resident's behaviors in the Kiosk and would tell the nurse.

On 10/29/15 at 3:15 PM, licensed nursing staff R stated the resident will call out at times, but did not remember the resident being physical. The aides were to document any behaviors and would let him/her know of any behaviors. The staff were to redirect the resident.

On 10/30/15 at 1:08 PM, administrative nursing staff S stated there should be a care plan for behaviors on the care plan if the MDS coordinator was alerted to the resident having behaviors.

On 10/30/15 at 10:19 AM, administrative nursing staff A explained that each individual nurse was responsible to update the care plans as needed.

On 10/30/15 at 1:13 PM, administrative nursing staff Q stated the residents would have a behavior care plan because the resident had more behaviors when he/she first came in compared to now.

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The undated facility policy for care plans documented the care plan will be updated as necessary which may be more often than at quarterly reviews.

The facility failed to review and revise this residents care plan to include instructions to the staff for interventions when behaviors occurred for this resident.

- The facility admitted resident #65 on 6/17/15, per the 10/20/15 signed physician's order sheet, with diagnosis of urinary retention (lack of ability to urinate and empty the bladder).

Staff recorded in the 6/29/15 urinary incontinence and indwelling catheter CAAS (Care Area Assessment Summary) the resident had an indwelling catheter.

The resident's 9/22/15 quarterly Minimum Data Set recorded a BIMS (Brief Interview for Mental Status) score of 12 (a score of 12 indicated moderate cognitive impairment), required extensive assistance of 2 staff for transfers and toilet use, used a wheelchair, and had an indwelling catheter.

The resident's 9/29/15 care plan, recorded staff removed the resident's catheter on 9/9/15 and reinserted the catheter on 9/23/15. An intervention dated 9/23/15, directed staff to change the catheter per the physician's order, monitor and chart output every day, and monitor for signs/symptoms of urinary tract infection. The resident's care plan failed to direct staff in the care of the resident's catheter tubing and failed to direct care to apply an anchor to the resident's

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catheter.

Staff recorded in the 9/23/15 nursing notes, at 7:05 AM, the staff received a physician's order to leave the urinary catheter in place, as the resident had problems voiding and emptying his/her bladder.

On 10/28/15 at 3:31 PM, observation revealed the resident in his/her room in a wheelchair with the catheter tubing touching the floor, under the wheelchair, in a length of approximately 3 inches. At 5:01 PM, observation revealed the resident in the dining room, in a wheelchair, and the catheter tubing touched the carpeted floor under the wheelchair, in length of approximately 8 inches.

On 10/29/15 at 8:22 AM, the resident verified he/she lacked any type of anchoring device in place to the catheter.

On 10/29/15 at 10:10 AM, direct care staff L stated he/she did not think the resident liked the leg strap on his/her thigh.

On 10/29/15 at 4:05 PM, direct care staff K stated staff needed to keep the catheter tubing off the floor.

On 10/29/15 at 6:07 PM, direct care staff M stated the resident came to the facility from the hospital and never had a leg strap in place.

On 10/29/15 at 6 PM, licensed staff G stated the resident had the catheter for urinary retention. Licensed staff G reported the staff needed to keep the catheter tubing off the floor. Licensed staff G state he/she was not sure about the facility's policy for the requirement of having an anchoring device in place to the catheter.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 14 On 10/30/15 at 10:10 AM, licensed administrative staff A stated staff needed to keep the tubing off the floor. He/she added staff should use some type of anchoring device on the catheter. On 10/30/15 at 11:01 AM, licensed staff E stated the floor nurses update the care plans, as needed. Licensed staff E stated the resident's care plan addressed the pericare and to change the catheter as per the doctor's orders, but was not completed updated when staff reinserted the resident's catheter on 9/23/15. On 10/30/15 at 10:20 AM, licensed administrative staff A stated the individual floor nurses needed to update the resident's care plans, as needed. The facility's undated comprehensive care plan policy recorded the care plan will be updated as necessary which may be more often than at quarterly review. The facility failed to review and revise the resident's care plan to direct staff in the care and treatment of the resident's catheter, when staff reinserted the resident's catheter on 9/23/15. - Review of resident #2's history and physical, dated 8-14-15, revealed diagnoses including neuropathy (disease of the nerves) and muscle weakness. The annual MDS (minimum data set), dated 4-7-15, assessed the resident with a BIMS (brief interview for mental status) score of 12, indicating moderate cognitive deficit, required extensive assistance with mobility, transfer, ambulation,	F 280		

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F 280	Continued From page 15	F 280		

dressing, toileting and personal hygiene. This MDS assessed the resident with unstable balance, only able to stabilize with staff assistance, always continent of bowel and bladder, and sustained no falls since the last assessment.

The quarterly MDS (minimum data set), dated 8-4-15, assessed the resident with moderate cognitive impairment, no behaviors, and required supervision for bed mobility, independent for transfer and walking in the room, and supervision for ambulation in hallways. This assessment assessed the resident with a balance steady at all times, no impairment of the upper and lower extremities, and unitized a walker for ambulation. This assessment assessed the resident sustained 2 or more non injury falls and 2 falls with injury since the prior assessment.

The CAA (care area assessment) for falls, dated 4-7-15, assessed the resident at risk for falls due to a previous history of falls, depression, diabetes, neuropathy, and use of diuretics. The resident used a mobility device and had a stooped forward posture.

The care plan, updated 10-2-15, advised the staff to walk the resident to meals with assistance and a walker, with the wheelchair to follow, as needed, to maintain and increase ambulation and endurance. The care plan advised staff to respond promptly to the call light, instruct and encourage the resident to use of the call system and keep items in reach. To keep the bed in a low position and the wheelchair locked when not in use. To keep the room clean, pathways clear, ensure clear access from the bed to the bathroom, monitor for safety hazards, shoes, foot wear on when up, and non skid socks on when in

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bed. However, this care plan lacked an updated intervention following the resident's fall on 10-23-15.

Review of the nurses' notes, dated 10-23-15 at 7:05 am, revealed the resident was being assisted into the dining room, utilizing a walker and gait belt. The resident's right knee buckled, and the resident fell onto the the dining room table, sustaining a right ear laceration, chin abrasion, and multiple ecchymotic (small purple spots) areas.

Observation, on 10-27-15 at 4:30 pm, revealed the resident seated in his/her recliner. The resident had sutures in their upper right ear, and was bruised (approximately 4 centimeters) underneath his/her chin, and had a blue ecchymotic area approximately 4 centimeters on his/her anterior left hand.

Observation, on 10-29-15 at 7:15 am, revealed the resident dressed appropriately, seated in the dining room in a wheelchair, eating breakfast.

Interview, on 10-29-15 at 7:15, am, with direct care staff L, revealed the resident required assistance with all activities of daily living, and did use his/her call light. Staff L stated the resident did not wish to ambulate this morning. Staff L stated the resident did require cueing for posture during ambulation to stay close to the walker.

Interview, on 10-29-15, at 8:25 am, with direct care staff X, revealed the resident required assistance with gait, and did use the call light.

Observation, on 10-29-15 at 12:53 pm, revealed the resident ambulated with a walker, in the hallway, with direct care staff W. The resident

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had a gait belt on and was leaning forward and took slow steps, the wheelchair was not behind the resident.

Interview, on 10-29-15 at 2:30 pm, with the resident, revealed the fall on 10-23-15, occurred early in the morning, and the resident felt staff did not allow enough time for him/her to awaken before getting dressed and ambulate to the dining room. The resident stated he/she would prefer to get up between 7:30 am and 8:00 am, and allow time to fully awaken before getting ready for the day and ambulating.

Interview, on 10-30-15 at 1:00 pm, with licensed nursing staff E, revealed the charge nurse on whose shift the resident had fallen, was responsible for updating the care plan, and confirmed the lack of an update completed for the resident's fall on 10-23-15.

Interview, on 10-30-15 at 1:15 pm, with administrative nursing staff C, revealed the intervention for the fall was to consult physical therapy for strengthening, but verified the facility did not have an immediate intervention to keep the resident safe.

The facility policy for fall management, revised 10/2015, advised staff if the resident continues to fall, the staff will re-evaluate the situation and consider other possible reasons for the resident's falling and will re-evaluate the continued relevance of current interventions.

The facility failed to review and revise the plan of care timely with interventions following a fall to prevent repeated falls for this resident.

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F 280	Continued From page 18 - Review of resident #60's signed physician progress note, dated 9-12-15, included diagnoses of macular degeneration (progressive deterioration of the retina), spondylolysis (breaking down of the vertebra) chronic renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), lyphedema (swelling caused by accumulation of lymph) to the right lower extremity, dementia with psychosis (progressive mental disorder characterized by failing memory, confusion, any major mental disorder characterized by a gross impairment in reality testing), depression (of sadness, worthlessness and emptiness) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The annual MDS (minimum data set), dated 2-17-15, assessed the resident with a BIMS (brief interview for mental status) score of 13 indicating intact cognitive status (13-15). This MDS assessed the resident was independent with transfers and mobility, required supervision for dressing and toilet use, required extensive assistance with personal hygiene, and no impairment in the upper or lower extremities. This MDS assessed the resident's balance as steady at all times, used a walker for ambulation and had two falls since the last assessment. The CAA (care area assessment) for falls/activities of daily living, dated 2-17-15, assessed the resident as at risk for injury due to not wanting or allowing staff to assist with his/her daily cares. The resident was independent, at risk for falls due to a decline in physical health, with the use of psychotropic medications, incontinence, paranoia dementia, and visual disturbance.	F 280		

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The care plan, updated 8-11-15, advised staff the resident was unable to stand up completely straight due to scoliosis/kyphosis (breakdown and curvature of the spine). Staff were advised to visually check the resident on rounds before bedtimes, and encourage the resident to use a walker for ambulation and a wheelchair for long distances. Staff was advised the resident often forgets to use the walker when in his/her room, Staff should promptly answer the resident's call light, keep the room clean, ensure clear access from the bed to the bathroom, monitor for safety hazards shoes, footwear when up and nonskid socks on when in bed.

Review of the facility's fall analysis for falls sustained 8-12-15 through 10-27-15 (6 falls), revealed the lack of new interventions added, other than adding tennis balls to the walker dated on 10-8-15.

Observation, on 10-27-15 at 3:10 pm, revealed the resident alert to person, seated in the rocking chair in his/her room. The resident's walker sat between the bed and the rocking chair foot rest. The resident had an ecchymotic area (small purple spots) on the back of his/her right leg measuring approximately 6 centimeter with a 3 centimeter purple fluid filled blister.

Interview, on 10-27-15 at 3:15 pm, with licensed nursing staff Z, revealed the resident had fallen several days ago and sustained a bruise to the his/her right leg and stated the blister was probably a result of the bruise. Staff Z stated the resident did should have staff supervision in his/her room, but often was found to ambulate independently. Staff Z stated the resident was confused at times, but the family wanted the

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F 280	Continued From page 20 resident to maintain independence. Interview, on 10-29-15 at 8:45 am, with direct care staff Y revealed the resident ambulated in his/her room independently with the walker, but staff should offer stand by assistance. Staff Y stated the resident did not always use the call light, and sometimes was resistive to care. Interview, on 10-29-15 at 4:14 pm, with licensed nursing staff G, revealed the resident did have episodes of confusion and did not use his/her call light for assistance. Staff G stated the resident slid out of his/her low bed on 10-14-15, and did not sustain any injury. Staff G explained that new interventions to the care care plan should be added to the care plan at the time of each fall. Interview, on 10-30-15 at 1:15 pm, with administrative nursing staff C, revealed the interventions for this resident depended on the resident's mood and willingness for staff intervention. Staff C explained the care plan was reviewed, and the family participated in the care plan meetings, but strategies for keeping the resident from sustaining accidents was difficult due to the resident's mental status. The facility failed to review and revise the plan of care with interventions timely to ensure this resident at risk for falls, did not sustain repeated falls. - The annual MDS (minimum data set), dated 6/9/15, for resident #33, revealed the resident had a BIMS (brief interview for mental status) score of 15, indicating intact cognition. The	F 280		

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F 280	Continued From page 21 resident required limited assist with bed mobility of 2 staff. The CAA (care area assessment) for ADLs (activities of daily living), dated 6/9/15, revealed the resident required assistance with ADLs. He/she required assistance with bed mobility. The care plan, reviewed on 9/15/15, lacked guidance for the use of the side rails on the resident's bed. Review of the side rail usage assessment, dated 10/20/15, revealed the resident wanted the top quarter rails on each side up, for assistance with repositioning and sitting up in the bed. On 10/28/2015 at 3:42 PM, direct care staff P, stated the resident's side rails were applied to the resident's bed a couple of weeks ago. At night, he/she tried to grab the book case located by the bed to help with turning. On 10/29/2015 at 9:03 AM, the resident explained he/she used the side rail to hold onto when staff was helping with changing his/her briefs at night. On 10/29/2015 at 10:39 AM, direct care staff O, stated the side rails were used to help the resident with bed mobility when pericare was provided. On 10/29/2015 at 12:59 PM licensed nursing staff H, stated the resident would grab the side rail when the resident was in bed and needed incontinent care. On 10/30/2015 at 10:07 AM, administrative nursing staff S, stated explained the side rail assessments were completed with each MDS or	F 280		

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F 280	Continued From page 22 change of status, and were documented in the care plan. The administrative nursing staff S, verified the care plan lacked documentation for the side rails. On 10/30/2015 at 10:19 AM, administrative nursing staff A, stated each nurse was responsible to update the care plan as needed. The facility's undated policy for comprehensive care plans revealed the plan indicated the resident's health needs,problems, and conditions. The care plan would be updated as necessary which may be more often than at quarterly review. The facility failed to review and revise the care plan to include the use of side rails for this resident who required assistance with bed mobility.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: The facility had a census of 97 residents and identified 7 residents with indwelling urinary catheters. The sample of 23 residents included one resident (#65) with an indwelling urinary catheter. Based on observation, interview, and	F 315		

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record review, the facility failed to provide appropriate treatment and services to prevent urinary tract infections and/or urethral trauma, for this 1 sampled resident (#65) with an indwelling urinary catheter.

Findings included:

- The facility admitted resident #65 on 6/17/15, per the 10/20/15 signed physician's order sheet, with diagnosis of urinary retention (lack of ability to urinate and empty the bladder).

Staff recorded in the 6/29/15 urinary incontinence and indwelling catheter CAAS (Care Area Assessment Summary), the resident had an indwelling catheter.

The resident's 9/22/15 quarterly Minimum Data Set, recorded a BIMS (Brief Interview for Mental Status) score of 12 (a score of 12 indicated moderate cognitive impairment), required extensive assistance of 2 staff for transfers and toilet use, used a wheelchair, and had an indwelling catheter.

The resident's 9/29/15 care plan, recorded staff removed the resident's catheter on 9/9/15 and reinserted the catheter on 9/23/15. An intervention dated 9/23/15, directed staff to change the catheter per the physician's order, monitor and chart output every day, and monitor for signs/symptoms of urinary tract infection.

Staff recorded in the 9/23/15 nursing notes, at 7:05 AM, received physician's order to leave the urinary catheter in place, as the resident had problems voiding and emptying his/her bladder.

On 10/28/15 at 3:31 PM, observation revealed the

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resident in his/her room in a wheelchair with the catheter tubing directly touching the floor, under the wheelchair, in a length of approximately 3 inches. At 5:01 PM, observation revealed the resident in the dining room, in a wheelchair, and the catheter tubing directly touched the carpeted floor under the wheelchair, in length of approximately 8 inches.

On 10/29/15 at 8:22 AM, the resident verified he/she lacked any type of anchoring device in place to secure the catheter from potential pulling with urethral trauma.

On 10/29/15 at 10:10 AM, direct care staff L stated he/she did not think the resident liked the leg strap on his/her thigh.

On 10/29/15 at 4:05 PM, direct care staff K stated staff needed to keep the catheter tubing off of the floor.

On 10/29/15 at 6:07 PM, direct care staff M stated the resident came to the facility from the hospital and never had a leg strap in place.

On 10/29/15 at 6 PM, licensed staff G stated the resident had the catheter for urinary retention. Licensed staff G explained the staff needed to keep the catheter tubing off the floor. However, Licensed staff G was not sure about the facility's policy for the requirement of having an anchoring device in place to the catheter.

On 10/30/15 at 10:10 AM, licensed administrative staff A stated staff needed to keep the tubing off the floor. He/she added staff should use some type of anchoring device on the catheter.

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F 315	Continued From page 25 Edition, directed staff to secure the indwelling catheter to the resident's thigh using tape, strap, adhesive anchor or other securement device to reduce pressure on the urethra exerted by the catheter. Allow some slack of the tubing to accommodate the resident's movements. The facility's undated policy for urinary continence and incontinence recorded if an indwelling catheter was needed, staff needed to anchor the tubing to secure the catheter tubing and keep the tubing off the floor. The facility failed to provide the appropriate treatment and services for this resident with an indwelling catheter, as staff failed to ensure the catheter tubing remained off the floor and failed to provide an anchoring device to the catheter to prevent possible trauma to the base of the bladder.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility reported a census of 97 residents. The sample of 23 residents included 3 reviewed for accidents. Based on observation, interview, and record review, the facility failed to ensure 2 (#2 and #60) of the 3 sampled residents timely interventions to prevent repeated falls.	F 323		

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F 323	Continued From page 26 Findings included: - Review of resident #2's history and physical, dated 8-14-15, revealed diagnoses including neuropathy (disease of the nerves) and muscle weakness. The annual MDS (minimum data set), dated 4-7-15, assessed the resident with a BIMS (brief interview for mental status) score of 12, indicating moderate cognitive deficit, required extensive assistance with mobility, transfer, ambulation, dressing, toileting and personal hygiene. This MDS assessed the resident with unstable balance, only able to stabilize with staff assistance, always continent of bowel and bladder, and sustained no falls since the last assessment. The quarterly MDS (minimum data set), dated 8-4-15, assessed the resident with moderate cognitive impairment, no behaviors, and required supervision for bed mobility, independent for transfer and walking in the room, and supervision for ambulation in hallways. This assessment assessed the resident with a balance steady at all times, no impairment of the upper and lower extremities, and unitized a walker for ambulation. This assessment assessed the resident sustained 2 or more non injury falls and 2 falls with injury since the prior assessment. The CAA (care area assessment) for falls, dated 4-7-15, assessed the resident at risk for falls due to a previous history of falls, depression, diabetes, neuropathy, and use of diuretics. The resident used a mobility device and had a stooped forward posture. The care plan, updated 10-2-15, advised the staff	F 323		

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to walk the resident to meals with assistance and a walker, with the wheelchair to follow, as needed, to maintain and increase ambulation and endurance. The care plan advised staff to respond promptly to the call light, instruct and encourage the resident to use of the call system and keep items in reach. To keep the bed in a low position and the wheelchair locked when not in use. To keep the room clean, pathways clear, ensure clear access from the bed to the bathroom, monitor for safety hazards, shoes, foot wear on when up, and non skid socks on when in bed.

Review of the nurses' notes, dated 10-23-15 at 7:05 am, revealed the resident was being assisted into the dining room, utilizing a walker and gait belt. The resident's right knee buckled, and the resident fell onto the the dining room table, sustaining a right ear laceration, chin abrasion, and multiple ecchymotic (small purple spots) areas.

Observation, on 10-27-15 at 4:30 pm, revealed the resident seated in his/her recliner. The resident had sutures in their upper right ear, and was bruised (approximately 4 centimeters) underneath his/her chin, and had a blue ecchymotic area approximately 4 centimeters on his/her anterior left hand.

Observation, on 10-29-15 at 7:15 am, revealed the resident dressed appropriately, seated in the dining room in a wheelchair, eating breakfast.

Interview, on 10-29-15 at 7:15, am, with direct care staff L, revealed the resident required assistance with all activities of daily living, and did use his/her call light. Staff L stated the resident did not wish to ambulate this morning. Staff L

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stated the resident did require cueing for posture during ambulation to stay close to the walker.

Interview, on 10-29-15, at 8:25 am, with direct care staff X, revealed the resident required assistance with gait, and did use the call light.

Observation, on 10-29-15 at 12:53 pm, revealed the resident ambulated with a walker, in the hallway, with direct care staff W. The resident had a gait belt on and was leaning forward and took slow steps, the wheelchair was not behind the resident.

Interview, on 10-29-15 at 2:30 pm, with the resident, revealed the fall on 10-23-15, occurred early in the morning, and the resident felt staff did not allow enough time for him/her to awaken before getting dressed and ambulate to the dining room. The resident stated he/she would prefer to get up between 7:30 am and 8:00 am, and allow time to fully awaken before getting ready for the day and ambulating.

Interview, on 10-30-15 at 1:00 pm, with licensed nursing staff E, revealed the charge nurse on whose shift the resident had fallen, was responsible for updating the care plan, and confirmed the lack of an update completed for the resident's fall on 10-23-15.

Interview, on 10-30-15 at 1:15 pm, with administrative nursing staff C, revealed the intervention for the fall was to consult physical therapy for strengthening, but verified the facility did not have an immediate intervention to keep the resident safe.

The facility policy for fall management, revised 10/2015, advised staff if the resident continues to

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fall, the staff will re-evaluate the situation and consider other possible reasons for the resident's falling and will re-evaluate the continued relevance of current interventions.

The facility failed to ensure timely interventions following a fall to prevent repeated falls for this resident.

- Review of resident #60's signed physician progress note, dated 9-12-15, included diagnoses of macular degeneration (progressive deterioration of the retina), spondylolysis (breaking down of the vertebra) chronic renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), lyphedema (swelling caused by accumulation of lymph) to the right lower extremity, dementia with psychosis (progressive mental disorder characterized by failing memory, confusion, any major mental disorder characterized by a gross impairment in reality testing), depression (of sadness, worthlessness and emptiness) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The annual MDS (minimum data set), dated 2-17-15, assessed the resident with a BIMS (brief interview for mental status) score of 13 indicating intact cognitive status (13-15). This MDS assessed the resident was independent with transfers and mobility, required supervision for dressing and toilet use, required extensive assistance with personal hygiene, and no impairment in the upper or lower extremities. This MDS assessed the resident's balance as steady at all times, used a walker for ambulation and had two falls since the last assessment.

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F 323	Continued From page 30 The CAA (care area assessment) for falls/activities of daily living, dated 2-17-15, assessed the resident as at risk for injury due to not wanting or allowing staff to assist with his/her daily cares. The resident was independent, at risk for falls due to a decline in physical health, with the use of psychotropic medications, incontinence, paranoia dementia, and visual disturbance. The care plan, updated 8-11-15, advised staff the resident was unable to stand up completely straight due to scoliosis/kyphosis (breakdown and curvature of the spine). Staff were advised to visually check the resident on rounds before bedtimes, and encourage the resident to use a walker for ambulation and a wheelchair for long distances. Staff was advised the resident often forgets to use the walker when in his/her room, Staff should promptly answer the resident's call light, keep the room clean, ensure clear access from the bed to the bathroom, monitor for safety hazards shoes, footwear when up and nonskid socks on when in bed. Review of the facility's fall analysis for falls sustained 8-12-15 through 10-27-15 (6 falls), revealed the lack of new interventions other than adding tennis balls to the walker dated on 10-8-15. Observation, on 10-27-15 at 3:10 pm, revealed the resident alert to person, seated in the rocking chair in his/her room. The resident's walker sat between the bed and the rocking chair foot rest. The resident had an ecchymotic area (small purple spots) on the back of his/her right leg measuring approximately 6 centimeter with a 3 centimeter purple fluid filled blister.	F 323		

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F 323	Continued From page 31 Interview, on 10-27-15 at 3:15 pm, with licensed nursing staff Z, revealed the resident had fallen several days ago and sustained a bruise to the his/her right leg and stated the blister was probably a result of the bruise. Staff Z stated the resident did should have staff supervision in his/her room, but often was found to ambulate independently. Staff Z stated the resident was confused at times, but the family wanted the resident to maintain independence. Interview, on 10-29-15 at 8:45 am, with direct care staff Y revealed the resident ambulated in his/her room independently with the walker, but staff should offer stand by assistance. Staff Y stated the resident did not always use the call light, and sometimes was resistive to care. Interview, on 10-29-15 at 4:14 pm, with licensed nursing staff G, revealed the resident did have episodes of confusion and did not use his/her call light for assistance. Staff G stated the resident slid out of his/her low bed on 10-14-15, and did not sustain any injury. Staff G explained that new interventions to the care care plan should be added to the care plan at the time of each fall. Interview, on 10-30-15 at 1:15 pm, with administrative nursing staff C, revealed the interventions for this resident depended on the resident's mood and willingness for staff intervention. Staff C explained the care plan was reviewed, and the family participated in the care plan meetings, but strategies for keeping the resident from sustaining accidents was difficult due to the resident's mental status. The facility failed to ensure timely interventions	F 323		

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F 323	Continued From page 32 were in place to ensure this resident at risk for falls, did not sustain repeated falls.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility had a census of 97 residents. Based on observation, interview, and record review, the facility failed to store food under sanitary conditions in 5 of the 9 facility's kitchens and in 1 of the 2 facility's kitchenettes. Findings included: - Review of the facility's 9 kitchens and 2 kitchenettes revealed the following areas/items of concern: 1) On 10/27/15 at 8:08 AM, observation in one of the kitchens revealed 5 wooden cabinets with porous shelves where the following items were stored: bagged cereal, waffle mix, napkins, Styrofoam and plastic cups. This porous shelf created a surface not easily sanitized. 2) On 10/27/15 at 11 AM, one of the two kitchenettes revealed the following outdated food items:	F 371		

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F 371	Continued From page 33 a) A container of fruit cup, dated 10/20/15. b) A piece of fried chicken in a plastic baggie, labeled with a resident's name and a date of "10/21". c) A gallon of 2% milk, with 1/4 of the milk remaining in the container, with an expiration date of 10/26/15. d) A gallon of unopened 2% milk, with an expiration date of 9/18/15. e) A Styrofoam box with food items, labeled with a resident's name and lacked a date. f) An opened container of boost plus, with the foil covering pulled back, and a resident's name and date of 10/26. g) Six slices of wheat bread with expiration date of 10/14/15. h) A whole loaf of white bread with expiration date of 10/29/15. i) Graham crackers with label which read best used by 10/3/15. j) Two packages of microwave popcorn with label which read best used by 8/28/15. k) One package of wheat crackers with expiration date of 4/24/15. 3) On 10/29/15 at 9:15 AM, in another kitchen's refrigerator, observation revealed a 5 pound container of cottage cheese with an expiration date of 10/24/15 and a block of cheese in a plastic bag which lacked a date when placed in	F 371		

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F 371	Continued From page 34 the plastic bag. 4) On 10/29/15 at 11:30 AM, in another kitchen, observation revealed a glass drawer had a plastic holder which revealed a break in the middle. In addition, the cabinet shelves noted with the veneer coming off. These surfaces created areas difficult to sanitize. 5) On 10/29/15 at 11:59 AM, in another kitchen's refrigerator, contained a 5 pound container of strawberry yogurt with an expiration date of 8/30/15 and a 12 ounce container of horse radish, with an expiration date of 4/6/15. At that time, direct care staff J verified the yogurt needed discarded and added, staff checked the food items every other day. 6) On 10/29/15 at 4:30 PM, in another kitchen, observation revealed the lower cabinets and drawers lacked any type of covering on the shelves which created a surface difficult to sanitize. On 10/29/15 at 2:50 PM, direct care staff X stated he/she checked for outdated food items as he/she used the food item. On 10/29/15 at 3:45 PM, dietary staff verified staff needed to ensure the available food items for the residents were not outdated. The facility's undated policy for food purchasing, receiving, and storage recorded it is the policy of the facility that food be properly stored to preserve flavor, nutritive value, appearance, and safety. Staff needed to store all foods or food items not requiring refrigeration on surfaces which facilitate thorough cleaning. Food needed dated with the current date and used or discarded	F 371		

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F 371	Continued From page 35 within 7 days. The facility failed to store food under sanitary conditions in these areas to prevent food borne illnesses.	F 371		